Management of Prisoners with Addictions
Discussion Paper Prepared for the NM Drug Policy Task Force
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Background Issues

- Journal of the American Medical Association, 2009: "Addiction remains a stigmatized disease not often regarded by the criminal justice system as a medical condition; as a consequence, treatment is not constitutionally guaranteed as is the treatment of other medical conditions."
- Approximately 85% of NM prisoners have some kind of substance use disorder; this is well above the national average of 65-70%. Rates of co-occurring mental disorders, especially those related to adult and childhood trauma, are very high in this population nationally.
- Managing addictive disorders during and after incarceration substantially helps the prospects for reintegration and is associated with reduced rates of both substance use and criminal recidivism, and a reduced overall number of prisoners. Without treatment, half of prisoners return to incarceration within two years; with treatment this number is reduced to 35%.
- Average annual costs per inmate were $41,000 in 2009, so addiction treatment is cost-effective when recidivism is reduced. ***There is a $7 reduction in the cost of drug-related crimes and criminal justice for every dollar spent on treatment in the community. This becomes a 12:1 return on the investment when savings on health care are also considered.***
- The high percentage of prisoners with substance use disorders is exacerbated by the large number of non-violent drug offenders incarcerated instead of receiving treatment in the community. In January 2011, 39% of the 6,637 New Mexico Corrections Department (NM CD) inmates were serving sentences for direct drug and/or alcohol crimes (eg, possession, DWI, trafficking, vehicular homicide when DWI, etc.), with an estimated cost annual cost $107 million (2009 costs). The additional number serving time for crimes committed because of drug use or to get money for drugs is unknown.
- Nationally, one out of four individuals released returns to prison within 3 years for a technical violation such as testing positive for drug testing.
- Ninety-five percent of prisoners return to their community. Releasing individuals with untreated substance use disorders can create a substantial burden on a local community's public health and public safety systems.
- On release from prison, addicted persons experience multiple challenges to their sobriety through various stressors that increase their risk of relapse to drug use: the stigma of being labeled an ex-offender, lack of finances and health coverage, the need for housing and employment, stresses in reunification with family, multiple requirements for criminal justice supervision, and often returning to a neighborhood that is rich with drug triggers.
- The post-release period also presents extraordinary health risks – in the first two weeks after release, former inmates are 129 times more likely to die from a drug overdose and 12 times more likely to die of any cause than non-inmates.
- Funding for treatment in prison, as well the overall NMCD budget, has been drastically reduced in recent years.

Substance Use Disorder Treatment in Prison

- Treatment in prisons generally consists of living in a therapeutic community (TC) or outpatient (OP) treatment. There is also a peer education program and AA and NA meetings are brought into correctional facilities.
- TCs have been well demonstrated to reduce recidivism (by 25-30%), and to also contribute to prison safety and security. Both minor and major disciplinary infractions are vastly reduced

among TC inmates (major: TC 0.2% vs. non-TC 10.8%; minor: 0.6% TC vs. non-TC 14.1%), and there are significantly fewer positive drug screens among TC participants.

- The NMCD Addictions Services Bureau (ACB) operates TCs in 11 prisons with a combined capacity of 768 beds (11.6% of all NMCD beds). There are 350 OP slots for an annual capacity of 700. Despite the high rate of substance abuse, the treatment capacity of 1,468 only covers 26% of the estimated 5,650 inmates with a substance use disorder under ideal conditions of full clinical staffing. In January 2011 there was a 30% clinical staffing vacancy rate and consequently, a clinical staffing ratio for inmates in treatment of only 1:29. Considering all inmates with substance use disorders, the ratio of clinical staffing inmates drops to 1:113.
- TCs are losing their effectiveness not just because of clinical staff deficiencies but also because of a lack of clerical support, a frequent transition of inmates because of classification transfers, a lack of opioid replacement therapy and overall poor funding.
- OP treatment is so poorly funded and staffed that it is essentially just drug education in some facilities, consistent with a national trend.
- *Peer recovery* is provided by volunteers from outside the prison system already in recovery from addiction – they are uniquely suited to help motivate inmates to want to change and to help in preventing drug relapse. They can continue to be resources after reentry. The Behavioral Health Collaborative provides training and certification for this work. The primary issues related to peer recovery are limitations in the ability of inmates to communicate with peer counselors, and difficulties in access for peer counselors.

Incarcerated Women

- Despite ample data that men and women with substance use disorders differ, treatment in prisons has traditionally been developed with men in mind. Prison programs developed for men have historically been imposed on women, and the women were then blamed when the programs are ineffective. Only recently in NM prisons have gender-specific treatments been offered to women which have improved their effectiveness. Much work is required, though, because NM has yet to develop or implement standards for gender-sensitive treatment.
- Although correctional facilities do exist for pregnant women and women with young children, the needs of this special population of women in prison are generally underserved.

Barriers to Inmates Obtaining Substance Use Disorder Treatment after Release

- Large numbers of inmates are uninsured after reentry to the community - in a recent study, after inmates were discharged from prison, 78% at 2-3 months and 68% at 8-10 months, respectively, had no public or private health coverage.
- Inmates are not eligible for Medicaid during incarceration so benefits are routinely terminated upon entry. Supplemental Security Income (SSI) are suspended for the first 12 months of incarceration, and then terminated. Social Security Disability Insurance (SSDI) is typically suspended after one month of incarceration, although SSDI benefits can continue to a spouse and children. Mechanisms to get prisoners enrolled in Medicaid, SSI or SSDI before discharge are sparse or nonexistent, so most eligible prisoners leave without coverage from these sources. In general, release planning for health care is severely lacking.
- There is a critical lack of funding for treatment services for parolees without insurance or with special needs. Budget cuts have been substantial in the past several years for those with substance use disorders on parole and probation.
- There is poor continuity between prison medical staff and community health providers.

Impact of Health Reform (the Affordable Care Act)

- The ACA has provisions that allow for all nonelderly adults (18-64) with income <139% (133% FPL plus a 5% income disregard) federal poverty level (FPL) to be eligible for Medicaid beginning in 2014. Other uninsured adults will qualify for the state insurance exchange, with those at 139-400% FPL income eligible for subsidies to pay for their insurance in the exchange. Currently there are 180,000 New Mexican adults that are uninsured and have <139% FPL, including most inmates.
- More than $11 billion is being made available to federally qualified health centers where many inmates could receive care after reentry for both substance use and mental disorders. The establishment of health homes could facilitate such treatment through these facilities.

Recommendations of the New Mexico Drug Policy Task Force

1. Prioritize a restoration of funding to the NM CD in the state budget, with an emphasis on appropriations for addiction treatment.
2. All prison staff should be educated about addiction as a chronic brain disease, to recognize the signs of substance use disorders and in the treatment of addiction.
3. NM CD and the Human Services Department (HSD) should collaborate to create mechanisms within the prison system such that during the pre-release period eligible prisoners will be enrolled in Medicaid, SSI and SSDI by discharge. Medicaid should be suspended instead of terminated for those already enrolled upon incarceration. In accordance with provisions of the ACA, individuals exiting correctional facilities should be considered a vulnerable and underserved population that the HSD will target for aggressive outreach and enrollment efforts for Medicaid. HSD should also utilize presumptive eligibility for Medicaid based on incarceration status, or use criminal justice system data to qualify prisoners for Medicaid.
4. Staff at prison reentry programs should partner with DOH and federally qualified health centers to help provide a seamless transition for reentry health care needs. This includes evaluating and improving the processes of information-sharing between Service Bureaus, in-house caseworkers, the Probation & Parole Division (PPD) and community services. This all implies that there will be a "handoff" for health care, addiction treatment and social needs (a continuum of care) from prison staff to community providers. NMCD and DOH should request funds to support this.
5. Expand addiction treatment services for uninsured and underinsured parolees and probationers. Prioritize the restoration of the budget in the PPD for addiction treatment, which will allow for the men's and women's Recovery Academies to again be utilized at capacity and for the reestablishment of the Dismas House for women.
6. Develop provisional policies for medication-assisted therapy (MAT) to:
    a. Require the NM CD medical vendor to assure that all of its physicians are certified and prepared to prescribe buprenorphine (Suboxone).
    b. Provide pre-release buprenorphine MAT to inmates with a history of opiate addiction prior to parole – this may be started with a pilot program. Buprenorphine should be administered via direct observational therapy (DOT) to prevent misuse.
    c. Provide inmates begun on buprenorphine with a seamless transition to a buprenorphine provider and for addictions treatment in the community.
    d. Require brief training for all prison staff (wardens, correctional officers, classification and case workers, etc.) and PPD staff of buprenorphine and other medication-assisted treatment (such as methadone) to enhance understanding and success.
    e. Make MAT training and information available to the parole board, sentencing commission and drug court personnel.

7. Co-occurring disorders in inmates with substance use disorders must be treated as part of a comprehensive treatment program in order to improve drug relapse and criminal recidivism outcomes.
8. Initiate utilization of the Reentry Drug Court Program § 31-21-27. This program allows the NM CD to recommend an inmate for early release into a community drug treatment program if the inmate was incarcerated for a nonviolent drug-related offense and is within eighteen months of release or eligibility for parole. Currently, this program is not being utilized because of procedural obstacles even though the DC has identified inmates who qualify.
9. Improve the peer counselor program by:
    a. Simplifying access to prisons by providing standardized volunteer training and a universal badge that would be recognized at every NM CD facility.
    b. Increase options for personal contact between peer counselors and inmates by utilizing videos and providing dedicated phone lines for calls to peer counselors.
10. Encourage utilization of the Alcoholics Anonymous (AA) "Bridge the Gap" Program which will connect inmates with AA members to facilitate participation in 12-step programs upon release.

References available